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ABSTRACT

This publication, through six chapters, discusses three exemplary methods of sharing resources in allied health education and provides allied health administrators and educators with an overview of the human factors needed for successful interinstitutional cooperation. Chapter 1 introduces the concept of cooperative sharing and provides the basis for the case studies (chapters 2-4) that follow. The Eastern Virginia Health Education Consortium case study illustrates an arrangement within a community or substate region and provides a model for interinstitutional planning. The Alabama Linkage Story describes a model of statewide sharing that links the resources of the state's junior colleges with specialized facilities and capabilities of an academic health center. The Mississippi-Louisiana Experience demonstrates a multistate sharing of resources where programs in occupational therapy and medical records administration are shared between two major institutions in adjoining states. Chapter 5 reviews the human factors needed to enhance successful cooperative activities. This chapter discusses proper environment, leadership, group dynamics, common goals, institutional missions, data base, human parameters, communication, perceptions, and documentation. Chapter 6 generalizes from the findings of the three case studies that sharing arrangements can provide advantages to allied health programs by extending resources, containing costs, avoiding duplication, and improving program quality. (BPB)

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# SHARING RESOURCES IN ALLIED HEALTH EDUCATION

Stephen N. Collier, Editor

Southern Regional Education Board
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Atlanta, Georgia 30313

1981

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FOREWORD

SREB's project in allied health education has sought to stimulate statewide planning and cooperation among educational programs. Dr. Stephen N. Collier, who initiated the project in 1978, was program director and project director until the summer of 1980, when he became associate dean of the School of Community and Allied Health at the University of Alabama in Birmingham. Under Dr. Collier's direction, the project stressed sharing as a practical means of extending resources in allied health education, and this publication was planned to illustrate such resource sharing.

The authors of the case studies have been the initiators and implementors of the programs they describe. In establishing the Eastern Virginia Health Education Consortium, Dr. Dale W. Lick, who was then the dean of sciences at Old Dominion University, promoted the Consortium concept. Dr. Stephen Moses, then coordinator of the Virginia program, helped guide the Consortium through its early period. Dr. Keith Blayney in Alabama took the initiative in organizing the Linkage program and has introduced innovations to strengthen and expand the effort. The Mississippi/Louisiana program began when Dr. Thomas E. Freeland and Dr. Stanley H. Abadie saw the opportunity for program sharing and negotiated an interstate agreement.

The present project staff expresses appreciation to the authors for preparing the case studies; to the editor, Dr. Collier, for his leadership in encouraging cooperative programs; and to the Division of Associate Health Professions, Bureau of Health Professions, Department of Health and Human Services for support of the project.

Harold L. McPheeters, Program Director

Pat Malone, Project Director

# CHAPTER 1 -- INTRODUCTION

Stephen N. Collier, Ph.D.

Associate Dean, School of Community and Allied Health
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Sharing allied health resources among educational institutions has been frequently discussed as a means of improving quality of instruction. The present era of budgetary constraints in higher education may stimulate resource sharing as a means of maintaining quality with limited funding.

Allied health education grew at a phenomenal rate during the late 1960s and early 1970s. State and federal funds facilitated the creation and expansion of educational programs and, between 1967-68 and 1975-76, the number of collegiate allied health programs in the South increased by 174 percent. In the same time span, the number of graduates increased sevenfold.[1] By 1975-76, there were 1,428 collegiate allied health programs in the Southern region.[2]

During the 1967-1975 period, the rate of growth of allied health programs exceeded the increases in resources in many cases, and some allied health curricula were overextended. In some institutions expansion had stemmed from

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[1]Eva C. Galambos, Implications of Lengthened Health Education: Nursing and the Allied Health Fields. Atlanta: Southern Regional Education Board, 1979.

[2]Allied Health Education Programs in Junior and Senior Colleges, Vol. 1, 1975. Washington, D.C.: Government Printing Office (DHEW Publication No. (HRA) 78-31), 1978.

a small funding base, with the hope that resources and adequate financing would follow.

The explosive growth of allied health programs crested by the mid-1970s, when education became less affluent and federal dollars became more difficult to acquire. Economic uncertainties at the end of the decade triggered fiscal constraints for all of higher education. Allied health, already spread too thin in many institutions, had serious financial problems and dim prospects for improved funding.

Allied health education is more expensive for institutions than many educational offerings. In those state higher education systems that use formulas of student credit hours to determine budget allocations, allied health programs often cannot generate sufficient allocations to support their costs. Institutions make up the deficit by using other educational budgets to underwrite allied health, but such subsidies are becoming increasingly difficult to maintain. At the same time, health-service providers and prospective students urge educational administrators to expand allied health programs. In many cases the formulas need to be revised to reflect actual cost of producing allied health education.

Prospects for Informal Sharing

The continuing shortage of allied health faculty with technical and educational qualifications is well documented. Faculty members tend to develop expertise in specialized areas of their disciplines, exacerbating the shortage, so that only programs with comparatively large faculties have comprehensive coverage in the subspecialties. Short-term faculty exchange or loans among

educational institutions can improve program quality by providing a critical mass of faculty for specialized instruction without the expense of adding numerous technical specialists to the faculty. Such faculty exchanges will require careful planning among the participating institutions and instructors to prevent or resolve any logistical problems that arise.

Systematic sharing of audiovisual materials among programs can make such materials more available and reduce costs. Audiovisual materials are often used in the highly technical allied health programs, particularly for illustration of particular procedures. Educators invest in expensive teaching packages, some of which are used for only a few days each quarter. These sharing arrangements can easily be documented in order to assure accreditation agencies that the desired audiovisual materials are available. Expensive and highly specialized kinds of equipment provide another inviting prospect for sharing between programs and institutions.

Yet another sharing possibility involves the courses or portions of courses within an allied health curriculum. A program may have a course or module that is unique or highly specialized. Materials developed for such courses may be shared among programs or, if several programs of the same type exist within close geographical proximity, it can be arranged that students from several programs attend the same course. Such a concept goes beyond program sharing of a core curriculum within a single institution. Courses in medical terminology, research methodology, and topics common to several allied health programs might be shared among programs in the same institution. Highly specialized or unusual courses in specific allied health disciplines can be shared among institutions. Since most educational institutions have provisions

for transient students to take individual courses, the major task of coordinating such efforts might be among allied health program directors.

Clinical facilities constitute another major potential sharing resource for allied health education. Many clinical facilities already accommodate students from several different educational institutions and programs. However, some clinical facilities that are under the administrative control of specific educational institutions restrict clinical education to students in their own institutions. Unique or highly specialized clinical facilities should be shared among institutions in order to provide clinical learning to as many students as possible.

Sharing Whole Programs -- The Academic Common Market

An alternative to establishing new academic programs in allied health is sharing specialized or unique academic programs at both baccalaureate and graduate levels. The Academic Common Market, sponsored by the Southern Regional Education Board, permits participating states to make arrangements for their residents to enroll in specific programs in other states at in-state tuition rates. States can thus offer their residents educational opportunities without having to invest large amounts of resources in educational programs that would have limited enrollments and which are already available in nearby states.

Several years ago, the Academic Common Market was reserved for graduate-level education and involved only a few allied health programs. Now undergraduate programs in allied health are included in the Market as well.

Another form of sharing may occur between adjacent states when educational facilities lie within commuting distance of two or more states. Within the

Southern region, there are approximately 110 institutions, (junior colleges, colleges, and universities) situated within 15 miles of a state line. Sharing both basic and advanced allied health programs across state lines may extend scarce resources for cooperating institutions and states. Such interstate arrangements can be accommodated within the Academic Common Market or through direct sharing agreements between the states.

Sharing at Various Levels -- Case Examples

Sharing of allied health educational resources can occur at various levels and settings, including within an institution; at the local, state, multistate, or regional level; or nationwide. The following chapters contain descriptions of sharing experiences at different levels.

The Eastern Virginia Health Education Consortium, described by Dale Lick and Stephen Moses, illustrates an arrangement within a community or a substate region. The Virginia Consortium provides a model for interinstitutional planning and for sharing of programs and supporting resources.

The Alabama Linkage Story by Keith Blayney describes a model of statewide sharing that links the resources of the state's junior colleges with the specialized facilities and capabilities of an academic health center. The program is more than 10 years old and has demonstrated its effectiveness in Alabama. Other states have initiated features of the Alabama model on a substate level.

The Mississippi-Louisiana experience described by Tom Freeland and Stanley Abadie is an example of multistate sharing of resources. In this instance, programs in occupational therapy and medical records administration are shared between two major institutions in adjoining states. This

arrangement has been successful in allowing each institution to use its unique strengths while relying on its neighbor to provide educational resources that would otherwise not be available. The result is that each institution offers its students a strong program in each discipline without financing duplicate programs.

To be successful, any type of interinstitutional cooperation and resource sharing must be built on trust and effective communications. Dale Lick describes some factors that must be taken into consideration in creating and maintaining cooperative agreements. Dr. Lick places particular emphasis on the human factors involved in negotiating successful cooperative activities.

The sharing arrangements described in this publication are only a few examples among many. Creative leadership from allied health administrators and educators can lead to sharing arrangements similar to those described in these chapters or to new approaches. This publication describes a few such arrangements to encourage the development of broader sharing activities in allied health education.

## CHAPTER 2 -- THE EASTERN VIRGINIA HEALTH EDUCATION CONSORTIUM

Dale W. Lick, Ph.D.

President, Georgia Southern College

Stephen Moses, Ph.D.

Director, Greater Lowell Area Health Education Center

The Eastern or Tidewater area of Virginia is the eastern third of the state bordering on the Chesapeake Bay and the Atlantic Ocean. Its colleges include the traditional College of William and Mary, community colleges, a prestigious predominately black private institute, regional universities, and a new medical school.

With a population of more than 1.3 million, the area has been viewed as a distinct region of the state. Like many regions of the South, it has had to create and use its own resources for growth and development. Also paralleling trends in the South, the past two decades have witnessed rapid development in government, transportation, housing, social services, and education.

As other changes were occurring, an informed public recognized the critical need to train health professionals for this area. However, the educational institutions did not have the resources necessary for health-professions education, such as a comprehensive university and the traditional health-professions schools.

Thus, Eastern Virginia needed a unique solution to its health manpower needs. A group of community leaders responded by giving high priority to

health professions program development, which led to the successful Eastern Virginia Health Education Consortium. The Consortium now provides leadership for the development and coordination of health-professions programs and services in Eastern Virginia.

Consortium Background

Regional academic health-professions program development began in the 1960s. In 1964, upon the urging of local community leaders, the General Assembly of Virginia chartered the Norfolk Area Medical Center Authority (now the Eastern Virginia Medical Authority) to assist in the development of health-care systems and health education in Eastern Virginia. It stimulated the area's higher education institutions to consider adding health programs to their offerings and established the Eastern Virginia Medical School in 1971.

Recognizing their interest in the cooperative development of health programs, the presidents of seven academic institutions signed an agreement in September, 1973, laying the foundation for such activities. In signing this document, the presidents recognized that:

> . . . the improvement of opportunities for education in the biological and health sciences for students in Eastern Virginia depends on the optimum utilization of available educational resources . . . and that this requires increasingly closer cooperation among their institutions . . . .

The original institutions involved were the College of William and Mary, the Eastern Virginia Medical Authority, Hampton Institute, Norfolk State College (now Norfolk State University), Old Dominion University, Virginia Wesleyan College, and Virginia Polytechnic Institute and State University. These institutions constituted what was known as the Presidents' Consortium.

Its goals were to 1) minimize duplication; 2) relate health service programs, regional hospitals, and institutions of higher education into an operational framework, and 3) use scarce resources in the most efficient and appropriate manner.

During the early phases much time was spent in developing a cohesive partnership among those who were responsible for health programs and elevating the priority for health programs in the region.

These discussions led to a more clearly defined, multi-institutional collaboration as well as to several formal cooperative arrangements among participating institutions. In January, 1976, the groups involved, with the support of the State Council of Higher Education (the coordinating agency for higher education in Virginia), embarked on a study to determine how to coordinate the planning and implementation of educational programs related to the health professions.

After the initial meeting, Virginia Wesleyan College and Virginia Polytechnic Institute and State University chose to withdraw from further active participation, and Christopher Newport College elected to become a member institution. Also, two outside health-related consultants were engaged, and representatives from the State Council of Higher Education for Virginia were invited to participate actively. These additions increased the group's objectivity, broadened its professional base, and tied it more closely to Virginia's planning and coordinating mechanisms. The group was named the Tidewater Area Health Education Committee (TAHEC), which ultimately was expanded into the Eastern Virginia Health Education Consortium. The TAHEC institutions are described briefly in Table 1.

TABLE 1 -- THE TIDEWATER AREA HEALTH EDUCATION INSTITUTIONS

| Institution | Location | Enrollment | Description |
|---|---|---|---|
| Christopher Newport College | Newport News | 3,000 | Public liberal arts college |
| College of William and Mary | Williamsburg | 6,000 | Public liberal arts university |
| Eastern Virginia Medical Authority | Norfolk | 1,000 | State chartered, locally supported, parent institution of the Eastern Virginia Medical School |
| Hampton Institute | Hampton | 3,000 | Traditionally black private college |
| Norfolk State University | Norfolk | 7,000 | Predominately black public university |
| Old Dominion University | Norfolk | 14,500 | Public regional university |

Cooperation and Planning

All health programs -- those at hospitals, vocational-technical schools, community colleges, universities, and the medical school -- needed to be included in the TAHEC study. This was too large an undertaking for one step, however, so TAHEC divided the effort into two phases. The first phase encompassed

programs at the baccalaureate and graduate levels, and the second phase considered programs below the baccalaureate level.

Among those representing the TAHEC institutions were vice presidents, deans and directors, and department chairpersons. The representatives had two things in common: 1) They had been appointed by their institutions' presidents to serve as institutional representatives, and 2) they had responsibility for the health programs on their respective campuses.

The study and planning that TAHEC undertook had the following purposes:

1. To discover whether these diverse institutions were willing to participate in cooperative and collaborative programs.
2. If so, to determine to what degree cooperation should be implemented.
3. To determine if such an arrangement could be implemented feasibly and in a manner acceptable to all institutions and beneficial to the community.
4. To assess the resources in health-professions education in Eastern Virginia.
5. To formulate a plan for the orderly development of academic programs in the health sciences and health professions.
6. To determine which level of health education programs should be addressed first.
7. To identify relationships with relevant organizations in Eastern Virginia.
8. To recommend the appropriate institutions to individually, collectively, or jointly meet programmatic needs as they are identified.

Through regular meetings, the group began to formulate a plan for the organization and implementation of educational programs related to the health professions. In July, 1976, TAHEC issued the report, "An Approach to Planning in Eastern Virginia for Academic Programs Related to the Health Professions." This document surveyed all existing programs in the health professions and described an organizational plan for the development and location of new baccalaureate and graduate programs.

The TAHEC report was significant because it was generated by a group of diverse institutions which traditionally had been isolated academically; together, they formed a dynamic plan that would benefit all. A precedent had been set. The institutions had begun to routinely meet and discuss the future. The idea of cooperative programming had come of age with the realization that this group, with differing identities and purposes, could accomplish objectives that no single institution could do alone.

With successful interinstitutional cooperation now a reality in the senior institutions, the TAHEC charge was expanded to include the hospitals, vocational-technical schools, and community colleges that prepare staff for the full array of health programs and health services. The enlarged group with an expanded role became the Eastern Virginia Health Education Consortium (EVHEC).

The Consortium

TAHEC, encouraged by the State Council of Higher Education for Virginia, expanded its efforts; its theme became "accessibility, excellence, and accountability," borrowed from the State Council's Virginia Plan for Higher Education.

The need to interrelate future programmatic and service development with other health resources in Virginia had been recognized and accepted.

The TAHEC work was a major beginning. It included a matrix for the development of future programs at the baccalaureate and graduate levels and represented a stable framework for multi-institutional cooperation. As TAHEC continued, its structure changed to meet the extended needs.

Organizational Structure

During the early phases of cooperation, TAHEC was small. This allowed the group to function as a unit on most matters, but it also provided the opportunity for the participants to interact continuously with one another, developing personal and professional relationships. A chairperson was elected; this individual, with the assistance of the group, provided the general leadership, coordination, and cohesiveness.

The TAHEC group often met for long sessions at both regularly and irregularly scheduled times, depending on the availability of its members and their other obligations. The Committee of Presidents for the TAHEC institutions acted as the policy board and final decision-making body. This Committee met three or four times a year.

The consultant fees and activities of TAHEC were paid from a central fund established by the member institutions. A proportional contribution was accepted, based on the number of health-related programs an institution had or expected to have. The budget was set, and funds were distributed by formal action of the group.

As the group went through transition from TAHEC to EVHEC, its membership increased and close personal relationships were more difficult to establish. Although not every institution participating in EVHEC had representation at each meeting, the group had become too large to function informally as a single unit as TAHEC had done. A chairperson was elected, and standing task forces were created in functional areas (e.g., manpower needs and demands, financial resources, and program development). Also, various ad hoc committees were established, as needed.

Funding for EVHEC activities was handled as it had been previously but with the TAHEC institutions bearing the largest portion of the budget. Eventually, EVHEC determined that professional staff was needed, and in January, 1978, EVHEC established a central office with a paid coordinator and secretary. The coordinator provided staff work and general direction for the group, and liaison with the institutions' presidents. The administrative structure continued successfully until September, 1979, when institutional financial exigencies led to a modified approach without a central administrative office, but with more dedicated administrative time given by each member institution on a rotating basis. The new approach is still in the formative stage as the Consortium continues its evolution.

Throughout all of the activities, the original TAHEC group has remained an effective leadership force and the many cooperative discussions between participating institutions have helped to clarify issues and enhance EVHEC's success.

## Results and Accomplishments

The development of the Consortium led to many accomplishments including: an environment for cooperation; an increased priority for health programs; coordinated health planning and program approvals; institutional and program affiliation agreements; additional outside funding; special conferences related to cooperation and articulation; increased awareness of minorities; and a number of spin-off programs and projects.

During the period before TAHEC was formed, there had been some movement towards cooperation, but, as the cooperative spirit of TAHEC began to grow, the institutions and their leaders became more aware of how interinstitutional cooperation could benefit the region as well as each institution. Although institutions maintained their unique identities, the psychology of cooperation provided the framework for improving relationships, setting common goals, and developing regional perspective.

The creation of an atmosphere of real cooperation is probably the single-most important result of the Consortium. People looked for ways to work together and to try to help one another. This led to increased sharing of facilities, resources, and expertise and a constructive approach to "How can we together accomplish our common goals?"

## Raising Priorities

Before TAHEC, health programs at the various institutions had been identified as areas for future growth, but no clear plan had been established. The work of the Consortium focused attention on health programs, highlighting major needs. For example, early surveys showed a severe shortage of appropriately

prepared health professionals and a lack of many common health-professions educational programs (e.g., health education, physical therapy, medical records administration, dietetics and nutrition, and graduate nursing).

These assessments and the other activities of the Consortium brought these manpower needs to the attention of the health community, the presidents and the faculties of the Consortium institutions, and state agencies such as the State Council of Higher Education. Without fully realizing it at the time, Consortium efforts highlighted health initiatives, resulting in their top-priority ranking. The Consortium emerged in a leadership role for the region and state.

Comprehensive Plans

In July, 1976, after numerous assessments and much hard work, TAHEC published its comprehensive plan for baccalaureate and graduate health programs in the report, An Approach to Planning in Eastern Virginia for Academic Programs Related to the Health Professions. A summary of the program aspects are outlined in Table 2. It should be noted that the concepts of "lead institution" and "cooperative and joint programs" in this report gave a framework for this cooperative plan for program implementation. Similar plans for health programs below the baccalaureate level are being completed.

Program Approval

The TAHEC report gave a master plan for health program development in Eastern Virginia and was broadly accepted as a reasonable blueprint for future program implementation. As a result, many of the programs have been approved by the State Council of Higher Education and are being implemented, including

TABLE 2 -- SUMMARY OF THE TAHEC PROGRAMS FOR BACCALAUREATE AND GRADUATE HEALTH PROFESSIONS

Definitions

Lead -- Home campus of the program but with significant sharing of the program with other institutions and their students.

Cooperative -- Individual degree programs but with significant sharing of staff, facilities, and course work.

Joint -- A single degree program with participating institutions providing approximately equal parts of the education.

Institutions

| | |
|---|---|
| Christopher Newport College | CNC |
| College of William and Mary | CWM |
| Eastern Virginia Medical Authority | EVMA |
| Hampton Institute | HI |
| Norfolk State University | NSU |
| Old Dominion University | ODU |

Baccalaureate

| | |
|---|---|
| Art Therapy | NSU (Lead) |
| Music Therapy | NSU (Lead) |
| Medical Records | NSU or CNC (Lead) |
| Medical Social Work | NSU (Lead) |
| Dietetics and Nutrition | NSU (Lead) |
| Dance Therapy | CNC (Lead) |
| Radiologic Technology | CNC (Lead) |
| Creative Arts in Human Services | ODU (Lead) |
| Physical Therapy | ODU (Lead) |
| Occupational Therapy | ODU (Lead) |
| Respiratory Therapy | ODU (Lead) |
| Health Education | CNC/HI/NSU/ODU (Cooperative) |
| Health Administration | CNC/NSU/ODU (Joint) |
| Recreation Therapy | CNC/HI/NSU/ODU (Joint) |
| Physician's Assistant | EVMA/NSU/ODU (Joint) |
| Pharmacy | EVMA/NSU/ODU (Joint) |
| Nurse Practitioner (Post-certificate) | EVMA/ODU/HI (Joint) |

Master's

| | |
|---|---|
| School Health Education | ODU or NSU/ODU (Joint) |
| Community Health | ODU or NSU/ODU (Joint) |
| Medical Technology | ODU (Lead) |
| Health Administration | ODU or EVMA/NSU/ODU (Joint) |
| Public Health | ODU or EVMA/ODU (Joint) |
| Dietetics and Nutrition | NSU/ODU (Joint) |
| Art Therapy | EVMA/ODU (Joint) |
| Nursing | HI/ODU (Cooperative) |
| Clinical Engineering | EVMA/ODU (Joint) |
| Clinical Science | EVMA/ODU (Joint) |
| Communication Disorders | HI or HI/ODU (Cooperative) |
| Gerontology | HI/NSU/ODU (Cooperative) |

Doctorate

| | |
|---|---|
| Psychology (Psy.D.) | EVMA/ODU/CWM (Joint) |
| Optometry | EVMA/ODU (Joint) |
| Health Education | EVMA/ODU (Joint) |
| Biomedical Sciences | EVMA/ODU (Joint) |
| Basic Medical Sciences | EVMA/ODU (Joint) |
| Clinical Sciences | EVMA/ODU (Joint) |
| Residency Programs for M.D.s | EVMA (Lead) |

baccalaureate programs in dietetics and nutrition, health education, medical records administration, and physical therapy; master's programs in health education, medical technology, and nursing; and doctoral programs in biomedical sciences and psychology. Several associate degree health programs have also been approved in conformity with the expanded master plan now being developed by the Consortium.

Agreements

Written agreements are critical to successful interinstitutional cooperation. They reflect the precise relationship between institutions and set forth the specific intent and conditions of the agreement. Among the most important agreements reached between the member institutions of the Consortium are the following:

1. Memorandum of Understanding. An agreement signed in September, 1973, by the presidents of seven academic institutions "to express their intent to promote cooperation among institutions of higher education and to foster and develop education programs in biological and health sciences in Eastern Virginia." This agreement served as the foundation for all future cooperative efforts in Eastern Virginia.
2. The TAHEC Report, discussed earlier, represented a published agreement of cooperation and long-range program development. The agreements reached in this document significantly reduced the "turf" questions and increased the likelihood of cooperation among institutions.
3. Program Endorsements. A document of endorsement for each new program developed to verify its ". . . appropriateness with the Consortium's

plan for orderly development of academic programs in the Health Sciences and Health Professions in Eastern Virginia" and to recommend the program's approval to the State Council of Higher Education. Each of these endorsements strengthened the program's chances for approval, since it certified consistency with the accepted master plan and put the full weight of all of the Consortium institutions behind the program.

4. Liaison Committee Agreements. Some pairs of institutions of the Consortium signed "Liaison Committee for Health-Related Programs" agreements. These further clarified the relationships between the two institutions and spelled out additional areas of collaboration and cooperation to be explored and developed between the institutions. The most active liaison committees were those between Norfolk State University and Old Dominion University, and between the Eastern Virginia Medical Authority and Old Dominion University. These special cooperative efforts not only helped collaboration between institutions, but often led to broad agreements for the entire Consortium.

5. Affiliation Agreements. From cooperative efforts among individual institutions came several affiliation agreements including:

   a) A faculty-exchange agreement between Norfolk State University and Old Dominion University.

   b) A student-exchange agreement between Norfolk State University and Old Dominion University.

   c) An agreement for jointly-sponsored hourly bus service between Norfolk State University and Old Dominion University.

d) A program affiliation designating student positions in the Old Dominion University Dental Hygiene Program to be reserved for matriculated students at Norfolk State University.

e) Academic programs for a doctor of psychology degree program (with the College of William and Mary, the Eastern Virginia Medical Authority, and Old Dominion University in association with Norfolk State University) and a Ph.D. degree program in biomedical sciences (jointly between the Eastern Virginia Medical Authority and Old Dominion University).

Outside Funding

Once effective cooperation and collaboration among Consortium institutions was substantiated, outside support could be sought. Among the several applications prepared, the Area Health Education Center (AHEC) proposal was clearly the most ambitious. On the third try, the application for an AHEC in Eastern Virginia was approved and funded for $600,000 for fiscal year 1980. If funded in future years as proposed, the AHEC should bring nearly $8 million to Eastern Virginia to assist in the development of health programs and services.

Agency Relationships

As the credibility of the Consortium grew, it was able to strengthen its relationships with area and state agencies. The State Council of Higher Education worked closely with the Consortium, assisting in obtaining approval for proposals and documents.

The Consortium institutions were increasingly accepted and respected by area hospitals and health agencies. The relationships with the Eastern

Virginia Health Systems Agency (HSA) and the Statewide Health Coordinating Council (SHCC) for Virginia were expanded and strengthened. At one time, seven of the 30 members of the board of directors of the HSA were from Consortium institutions, and one Consortium person was also a member of the board of directors of the SHCC. The hospitals and health agencies turned more readily to the Consortium for assistance as its influence increased.

Minority Advancement

From the onset, the group was aware of the shortage of minorities in the health professions. Several programs were developed to address this problem, including placing health programs at minority institutions, student and faculty exchanges, program affiliation agreements, and bus service between campuses.

Spin-off Projects

Consortium successes provided impetus for several other programs and projects. During the period of cooperation, the Eastern Virginia Medical Authority, the hospitals, and Old Dominion University teamed up to establish a cooperative program for inservice education for area hospital personnel, called the Shared Staff Development Program. This program provides an impressive array of shared inservice education offerings for personnel in 25 of the area's hospitals.

Regional planning in Eastern Virginia has now become a model for other regions of the state and for other academic disciplines. The State Council of Higher Education encourages such cooperation and, in fact, has made it mandatory for certain disciplines, e.g., health education.

The Consortium leaders have played key roles in the establishment of organizations and conferences dealing with such community concerns as hunger, malnutrition, and gerontology. One of the hunger and malnutrition conferences drew approximately 3,500 people and is believed to be the largest of its type ever held in the United States.

Recognition and Dissemination

The Consortium has received regional, state, and national recognition. In addition, it has been invited to make formal presentations to the Virginia Association of Allied Health Professions, to the 1978 Urban South Conference, to an advanced national workshop for health administrators on "Interinstitutional Cooperation Arrangements" sponsored by the American Association of State College and Universities, and to the National Commission on Allied Health Education.

Summary

The EVHEC illustrates how higher education cooperation can meet a region's needs. The successes in Eastern Virginia did not come easily, but depended upon the genuine commitment of many, and the dedication of area leaders. Cooperation in this instance meant leaders rising above the constraints of time, history, and their institutions to develop a regional approach to cooperative programs and services.

# CHAPTER 3 -- THE ALABAMA LINKAGE STORY

Keith D. Blayney, Ph.D.

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University of Alabama in Birmingham

Until the late 1960s, the state of Alabama was seriously short of physicians, nurses, and all kinds of health manpower. This shortage included technicians and specialists in the allied health professions, as a survey by the Comprehensive Health Planning Agency in 1972 documented. For example, at that time there was a deficit of 61 radiologic technicians and 80 cytotechnologists, and there were no physical therapists in the state.

The June, 1972, issue of Appalachia Magazine pointed out the difficulties experienced by rural communities in the region in obtaining medical care. While the article dealt primarily with the problems of attracting physicians to such areas, it also emphasized the need for support personnel -- trained allied health workers who could be an important part of the health-care delivery system. Without these vital workers, physicians were reluctant to set up practices.

During the early 1960s, a network of junior colleges was established under the Alabama Department of Education. Less expensive than four-year institutions, the junior colleges served students within commuting distance of their homes. However, the junior colleges had not established allied health programs for two reasons: 1) They lacked the funds to purchase the

complex equipment used in allied health training programs, and 2) they were unable to recruit qualified faculty.

The expense of training only a few students in an allied health career program would have been prohibitive for most junior colleges, although training programs were needed where the potential workers lived. Another plan was required. It took the form of a consortium -- a method of interinstitutional sharing that became the Junior College/Regional Technical Institute Linkage Program (or Linkage), which is a component of the School of Community and Allied Health at the University of Alabama in Birmingham.

In 1969, the state's junior college presidents and representatives of the University of Alabama in Birmingham (UAB) met and endorsed the concept of a consortium to link the two-year schools with UAB. The benefits were readily apparent -- by "sharing" students with the Regional Technical Institute (RTI) at UAB, the duplication of specific allied health programs and their high costs could be avoided. Also, students could attend school near their homes for the first year of the program. After the second year at RTI, graduates were likely to return to their homes, located in the medically underserved areas of the state, and provide ancillary support for medical services there. As the program developed, efforts were made to establish clinical training sites for the students in or near their homes, thus providing an additional impetus to return home.

Funding from the Alabama Regional Medical Program and the W. K. Kellogg Foundation gave a financial boost to the planned consortium. Other funding was provided by the state of Alabama, federal grants, and private agencies. On November 3, 1970, a formal agreement was signed by the State Board of

Education, the governing body for the two-year colleges, and the University of Alabama in Birmingham. This document defined the areas of responsibility for developing the Linkage; the following year another agreement, implementing the program, was signed.

The agreement for the Linkage established the responsibilities for both the junior colleges and the RTI. Certain core courses are taught during the first year at the junior college, satisfying the state's requirements for an associate degree. The students then attend RTI for approximately one year's training in an allied health field. There are now 10 different allied specialty training programs:

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| Biomedical equipment technicians | Radiographers |
| Medical record technicians | Respiratory therapists |
| Medical laboratory technicians | Multiple competency clinical technicians |
| Occupational therapy assistants | Medical assistants |
| Physical therapist assistants | Emergency medical technicians |

After successfully completing this training, each student receives an associate degree from the junior college and a certificate of completion in the appropriate allied health field from the RTI.

Junior college representatives were concerned that their schools might lose some autonomy by joining into a linkage with one of the state's largest universities. UAB had already agreed to keep RTI tuition in line with that of junior colleges. To address other concerns, representatives of the junior colleges, the State Department of Education, the Alabama Regional Medical Program, the Alabama Office of Comprehensive Health Planning, and the RTI met and

agreed on a common curriculum design, with mutually acceptable prerequisites and training procedures. The result was a closer understanding between the junior colleges and the RTI.

To avoid duplication, a central office was established on each junior college campus for coordinating information with the RTI. Each school designated a person to serve as the on-campus coordinator for the Linkage program. The coordinators' responsibilities were to provide information on administrative and educational aspects of the Linkage for their respective colleges, and to serve as contacts for students who were potential Linkage students.

Ideally, the decision to enter the Linkage program is made by a student either before beginning junior college training or in the first quarter. Because of the diverse requirements of the 10 different allied health programs available at RTI, junior college students must augment their core courses with subjects related to their specialty areas. For example, students interested in the Multiple Competency Clinical Technician Program would need background courses in chemistry, while persons wanting to pursue the Medical Records Technician Program would need typing courses. The counselors and Linkage coordinators on the junior college campuses are prepared to help the prospective Linkage students make these decisions.

Since the junior college awards an associate degree to the graduating Linkage student, certain academic courses are also required. A student entering the Linkage program after two or more quarters at the junior college needs to complete these required courses before attending the RTI.

As the October, 1977, report by the W.K. Kellogg Foundation, "Action Programs for Developing Health Educators," pointed out in discussing the Linkage,

several principles were established for designing the junior college curriculum:

1) Subjects required of the students must be common to a maximum range of allied health specialties.

2) Course work should be transferable to other disciplines if at all possible.

3) To avoid duplication of staff and equipment, allied health subjects should not require additional staff or additional laboratory equipment.

4) Subjects should be within the range of expertise of the junior college teachers.

5) Specifics of pretechnical training could be included in existing courses.

6) Developing specially designed courses should be kept to a minimum.

7) The courses should be practical, so that they are worthwhile even if the student doesn't enter the health field.

Instructors can have more individual time with each student because class sizes are limited. Only a relatively small number of applicants are accepted for each RTI Linkage program, so that an admissions committee reviews each applicant and determines who is accepted.

Before their year of technical training at the RTI ends, the students spend six to eight weeks in on-site clinical training. Although the RTI is located in the heart of UAB's Medical Center, where there is a large volume and variety of clinical materials, it soon became clear that the Medical Center alone would not be sufficient to provide adequate experience for all the allied health students. As a result, Linkage students can now complete the last weeks of their clinical training at smaller health-care facilities throughout the state. These facilities range from doctors' offices to nursing homes, clinics, and hospitals. This arrangement has other advantages. The students can work close to their homes, in facilities similar in size and scope to those in

which they will probably work. Also, upon graduation, the students are often offered positions at the facilities where they did their training.

Since the number of clinical facilities has been expanded, a higher percentage of RTI graduates have returned to rural areas to work. In 1977, 59 percent of graduates of programs that have clinical training sites outside of Birmingham took jobs outside of the city, while only 34 percent of the graduates who had no clinical affiliation outside Birmingham left the city.

Major considerations in selecting clinical sites are the willingness and capability of the facility's staff to supervise the students and the facility administrator's realization and acceptance that the clinical learning experience is important. After the initial contacts with health-care facilities that are being considered as clinical training sites, meetings are held with the administrators and other staff to explain the program and how it involves the facility personnel.

Written agreements spell out the mutual and separate responsibilities of the school, the students, and the clinical facilities. Areas that are clarified in these agreements are liability-insurance coverage, student stipends, and estimates of the personnel time and supplies that will be required from the facilities.

The clinical facilities then have a period of several days to several weeks to consider the agreements and make adjustments to suit their particular situations. If satisfactory terms can be arranged, the agreements are signed by both parties.

Once the agreement is signed, the clinical faculty begins an orientation program, either at the School of Community and Allied Health in the UAB

Medical Center, the clinical facility, or both. Program faculty and clinical instructors discuss what student performance is expected and outline techniques to evaluate student progress. A method of communication is also established to handle problems that arise during the clinical training.

The final phase in the development of the affiliation occurs when the students are actually at the clinical site. The students, clinical instructors, and RTI faculty communicate regularly. A faculty member makes at least one visit to the site during each student's placement.

Both the students and the clinical instructors are debriefed at the UAB campus following the site training.

In 1974, the Alabama Regional Medical Program funded two conferences that brought together 80 science instructors from 21 junior colleges to discuss curricula, course content, and scheduling. Junior college courses were analyzed, and appropriate prerequisite courses for the Linkage programs were determined. This information was subsequently included in the catalog of each two-year school.

One of the special needs of Alabama physicians in small clinics was for a person who could combine business administration skills with basic nursing and laboratory capabilities. The RTI met this need by offering the Multiple Competency Clinical Technician Program -- one of only five or six in the nation. As with other RTI programs, a community assessment was done to determine what should be included in the curriculum. The result is a program specifically designed to meet the needs of small hospitals and clinics.

In addition to the state's public junior colleges, three private institutions became a part of the Linkage. In 1975, when it began to offer the

two-year associate degree, Livingston University became the first four-year school to join. In 1978, the RTI took on a truly regional flavor when Motlow State Community College in Tullahoma, Tennessee, joined the Linkage. Negotiations are also in progress with other institutions in Tennessee.

In retrospect, the Junior College/Regional Technical Institute Linkage Program has accomplished more than its originally intended purposes. The Linkage has established a quality training center for allied health students with the emphasis on returning them to their home communities, and it has helped to alleviate the health manpower shortage in the rural areas. The junior colleges have benefited through the enrollment of students who might otherwise have never attended. Moreover, the RTI has become a model for training allied health professionals. The consortium has been visited and studied by representatives from 30 states and six countries. One state official has termed it "the most innovative approach to education in years."

The RTI has also saved money -- both for students and the state. The state realizes a considerable savings by avoiding the duplication of allied health programs in several different junior colleges. The students save on tuition: Linkage students attend RTI at less than half the amount per quarter charged by UAB. A survey of costs in other states with similar programs indicates that RTI's tuition is considerably less.

The family income of students attending two-year public institutions is usually considerably lower than the family income of students attending four-year colleges. One study indicates that 65.2 percent of the families of the students in junior colleges have an income below $9,000 a year. The Linkage program, with its first year of training at a school near the student's home

and only one year away from the home community, gives the prospective allied health professional the opportunity to obtain a quality education and learn a highly marketable skill without an unduly heavy expense to the family.

The Linkage is a major resource to prepare students to enter a job market in the allied health industry, where a continued growth is expected throughout the 1980s. Five elements are recognized as essential to the success of the program:

1) Trust between institutions, generated by holding regular meetings of the junior college presidents and the program coordinators at the RTI.
2) Early distinctions regarding the roles the various institutions were expected to play.
3) Designating one person at each institution to be responsible for the program.
4) Central recruiting and admissions procedures.
5) Establishment of clear admissions criteria for each of the 10 health programs.

Institutions interested in setting up similar programs are urged to consider how to handle the problem of housing students at the central facility to avoid the housing crunch that the RTI has encountered.

In May, 1979, the School of Community and Allied Health and the RTI marked a decade of growth. In that period, the school became the largest of the five schools comprising the UAB Medical Center. A joint resolution from the Alabama legislature, signed by Governor Fob James, recognized the school's accomplishments and praised the Linkage, stating that it "has made available training

for many Alabama citizens who otherwise would not have been able to pursue allied health training." Governor James commented that "The Junior College/ Regional Technical Institute Linkage represents a model approach for higher education. It is cost-effective and assures quality."

The Junior College/Regional Technical Institute Linkage Program is a simple solution to a complex problem: locating, training, and placement of allied health workers in smaller communities. The success of the program has caused UAB's School of Community and Allied Health officials to look at other ideas for developing allied health manpower. One proposal is to provide training for technicians who are already employed but who have not received formal instruction in their field. Through training modules developed by the RTI Linkage faculty, employees at low level jobs could learn advanced skills while remaining on the job. This incentive for upward mobility would not only improve the quality of performance of these employees but also help reduce personnel turnover in these jobs. The employees would also be prepared to advance and receive the Associate Applied Science Degree.

Such variations of the Junior College/RTI Linkage Program are becoming more apparent as the Linkage grows and develops. The possibilities of using the model for allied health personnel training are limitless. The Linkage can be the answer to the problems of distribution of health workers for Alabama and perhaps for the nation as well.

# CHAPTER 4 -- THE MISSISSIPPI-LOUISIANA EXPERIENCE

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## Background

Beginning in the mid-1940s, every study of health care resources in Mississippi revealed the state's critical shortage of health manpower. Steps were taken to educate more physicians and nurses, but attention was not focused on allied health personnel until 1974, when the Board of Trustees, State Institutions of Higher Learning, named an Advisory Research and Planning Committee for health-related occupations and professions. The committee was charged with assessing the present status and projecting the future needs of the health occupations in Mississippi, reviewing health manpower employment, and compiling a report to serve as a baseline for future planning.

The committee report was published in the summer of 1974.[1] It concluded that the state's many education programs for health occupations were producing

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[1]Health Occupations Education and Training Programs in Mississippi: Present Status and Future Needs. Published for the University of Mississippi Medical Center School of Health Related Professions in the Department of Special Services and Campus Relations, Summer 1974.

too few graduates; that many graduates were failing certification tests; that manpower deficits were being filled by untrained persons; that qualified faculty were lacking; and that costs were excessive.

Almost simultaneously, the School of Health Related Professions completed a companion study to undergird an application for grant funds to establish what is now known as Project SNAP (Statewide Network for Allied Health Programs). This document stated that the Mississippi Hospital Inventory, published in 1971, reported that only 6.5 percent of hospital employees were registered or licensed in their fields and that at least 500 new allied health personnel would be required every year for 10 years to bring the state to acceptable ratios of personnel to population. The report recommended that physical therapists increase 200 percent; dental hygienists, 300 percent; and occupational therapists, an overwhelming 1,200 percent.

Not one of the state's 43 postsecondary institutions prepared students to provide restorative services, although 29 colleges offered one or more allied health programs. Meanwhile, the state's hospitals reported only 162 restorative service workers of all types for 16,008 hospital beds.

The Project SNAP proposal (funded by the Veterans Administration for seven years) accepted three key premises:

1. A coordinated educational system for allied health personnel could balance supply with demand, insure high-quality preparation, control educational costs, and distribute the cost and graduates over the widest possible base.

2. Cooperative efforts for all formalized allied health education programs, regardless of the certificate or degree, would be good for the institutions and also benefit the students, the state, and the consumers of health services.
3. The University of Mississippi Medical Center had a primary role and responsibility in providing superior education in health-related professions.

Although it fully appreciated the extraordinary deficit in occupational therapists in Mississippi, the School of Health Related Professions could not justify initiation of an occupational therapy program because of fiscal, faculty, and clinical facility limitations; nor could it find adequate resources elsewhere in the state.

Both Louisiana State University and the University of Mississippi have long histories of educational leadership in their respective states. Like the University of Mississippi, Louisiana State University had several campuses, with its School of Allied Health Professions at the LSU Medical Center in New Orleans (LSUMC). That school offered an upper-division baccalaureate degree program in occupational therapy. It did not have a medical record administration (MRA) curriculum even though it had access to excellent sites for clinical experience; it elected not to add this program because long-term demand was uncertain. On the other hand, the University of Mississippi School of Health Related Professions at the Jackson Medical Center offered an upper-division baccalaureate MRA program. Because the LSUMC occupational therapy

program enjoyed more-than-adequate clinical facilities for third-year (junior) students in the immediate New Orleans area, the program was expanded to accommodate Mississippi students. In keeping with the LSU philosophy that clinical field-work experience should be in the area where students will ultimately choose to reside, arrangements were made for Mississippi students to have occupational therapy field-work experience at several excellent clinical centers in their own home state.

Development

At the eighth annual meeting of the American Society of Allied Health Professions in Philadelphia in 1975, deans of allied health schools in mid-South medical centers informally discussed the possibility of interstate cooperative arrangements to provide allied health educational opportunities not then available in their respective states. Over the next 18 months, Dr. Stanley H. Abadie, the Dean at the School of Allied Health Professions at LSUMC, and Dr. Thomas E. Freeland, the Dean at the School of Health Related Professions at the University of Mississippi Medical Center, informally pursued the subject.

As these discussions progressed, the advantages of a cooperative exchange program emerged and subsequently evolved into the following objectives:

1. Each of the participating institutions could rely on an existing, accredited program to increase enrollment and to provide a broader-based educational opportunity through additional clinical affiliates.
2. The existing programs, on which the exchange process was predicated, would offer an immediate, educational option not then available within each school's geographic service area.

3. Resources required to enroll a modest number of additional students would be significantly less than those necessary to initiate a new educational program in allied health.
4. Each participating program could make efficient use of resources and enhance the cost-benefit return for all programs.

After six months of discussion between the two deans and their appropriate constituent groups, the Mississippi Board of Trustees, Institutions of Higher Learning, authorized negotiation with the sister institution in Louisiana in August, 1977.

Each dean discussed the exchange process with the faculty of each of the educational programs, the chief executive officers of the health sciences campuses, and other administrative personnel. Each dean also talked to professional organizations, potential clinical affiliates, prospective employers, and other vested constituent groups to elicit their reactions and to examine the opportunity for an exchange agreement. As problems related to program funding, admissions, academic control, and the development of clinical affiliations were resolved, responses became uniformly encouraging.

The deans and the respective department chairpersons drafted Articles of Agreement and submitted the draft articles through the appropriate committees or administrators at their respective campuses. Proposed modifications were negotiated as the draft moved through the administrative levels to the governing bodies of each institution. Formal approval of the Articles of Agreement by the Board of Supervisors of the Louisiana State University and the Board of Trustees of the Mississippi Institutions of Higher Learning, was given in February, 1978.

The LSU School of Allied Health Professions agreed to accept up to five Mississippi occupational therapy students annually, and the University of Mississippi School of Health Related Professions was to accept up to five Louisiana MRA students annually. Each applicant was to be screened by the home state school's Admissions Committee. Each school agreed to summarize its selection process and student profile data, to offer unpaid adjunct-faculty appointments to the other school's program coordinator, to waive out-of-state tuition, to require completion of the final clinical practicum in the home state, and to award the appropriate degree upon successful completion of the program. In turn, each school agreed to select and refer students who fit the profile, to develop and supervise in-state practicum sites, and to employ professionally qualified personnel to administer its component. The initial three-year agreement could be renewed, extended, revised, or canceled by mutual agreement.

Operational policies completed in May, 1978, supplemented the Articles of Agreement to cover such topics as preapplication counseling, application procedures, and notification of acceptance by the home state school. The home school assesses and retains its regular application fee but waives deposit fees. Exchange students are eligible for financial assistance from the degree-granting institution. Exchange-program coordinators are in frequent communication with their counterpart department chairpersons and faculties and collaborate on such matters as selection of the program coordinators and the work of the admissions committees. No significant decision related to the exchange program is made without consultation between the schools.

No funds are transferred between schools. Each school conducts its budgetary process without review or approval of the other. The University of Mississippi School of Health Related Professions has budgeted a part-time coordinator and a part-time secretary and related costs from state and sponsored program funds. At LSU School of Allied Health Professions, the associate dean of the school serves as liaison and coordinator until such time as a medical record student returns to Louisiana for clinical training, when a professionally qualified person will become coordinator.

Curriculum is the sole responsibility of the faculty of the degree-granting institution. However, all program modifications are reviewed by the cooperating school before going into effect. All issues have thus far been resolved within the framework of the existing policies.

Immediately after approval of the Agreement in February, 1978, the School of Health Related Professions began student recruitment through its customary mechanisms, and Project SNAP field staff publicized the new program throughout Mississippi. A brochure was designed to fit in the school's recruitment packet, and in the summer of 1979 a 12-minute videotape was produced. This tape has proved helpful in both student recruitment and orientation. The LSU School of Allied Health Professions informed all advisors and counselors on the campuses of the LSU system that the medical records program was available, and promoted the program at their annual workshop for advisors and counselors from all institutions of higher education in Louisiana.

The School of Health Related Professions enrolled two Mississippi students in the occupational therapy program in the spring of 1978 and two more in June,

1979. As of the fall, 1979, four Mississippians were working toward occupational therapy degrees in New Orleans, and one Louisianian was enrolled in the medical record administration program in Jackson. (Louisiana students may also obtain the MRA degree at the University of Southwestern Louisiana in Lafayette and Louisiana Technical University at Ruston.)

Effective June 1, 1979, the University of Mississippi Medical Center employed one person to be director of the occupational therapy department in its University Hospital, coordinator of the occupational therapy program, and assistant professor of interdisciplinary and cooperative education in the School of Health Related Professions. This person's time and salary were divided between the hospital (70 percent) and the school (30 percent). Three clinical sites were initially approved, one on the Gulf Coast and two in Jackson, and arrangements were underway for others. Several clinical training sites for MRA students were developed in Louisiana.

The program is fulfilling its basic objective of providing a small number of well-trained allied health professionals in disciplines which are in short supply. The exchange program cannot provide either state with all the professionally prepared manpower that is required, but it offers a rational approach to sharing programs that the institutions would not otherwise be able to offer to residents of their geographic service areas.

# CHAPTER 5 -- THE HUMAN FACTOR IN SUCCESSFUL INTERINSTITUTIONAL COOPERATION

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## Introduction

Significant interinstitutional cooperation can be accomplished in almost every setting where there are two or more institutions, genuinely interested parties, and rational guidelines. This chapter discusses some of the human elements leading to successful interinstitutional cooperation.

## Proper Environment

The need for cooperation has been summarized nicely by the former U.S. Commissioner of Education, Dr. Ernest L. Boyer: "The need is to cooperate, not because it is the 'gentlemanly' thing to do, but rather because it is the urgent thing to do."

At no time since the mid-1950s to early 1960s have institutions been faced with greater specific constraints or more pressure for their services. As a result, institutions which insist on independence are finding resources and support harder to obtain. Interinstitutional cooperation not only is the best use of resources but also helps establish credibility among support groups.

If institutional officials do not appreciate the urgency of cooperation and the potential it holds, cooperative efforts will probably not be successful

for that institution. The best environment is one in which the institutional leaders, particularly chief executives, understand and enthusiastically support cooperation. In the early stages of cooperation, the encouragement of the faculty and colleagues is helpful, but not critical; later, they must be reasonably committed if cooperation is to succeed.

Leadership

Liaison activities with outside agencies are the responsibility of top management, and therefore, cooperation should not be delegated initially. The support from the administration should be visible. In cooperative efforts among several institutions, each usually sends a representative to meet with those from the other institutions to agree on how the institutions might cooperate. Ideally, this representative should have as many of the following characteristics as possible:

1. A strong personal commitment to cooperation or at least the capability to develop such a commitment.
2. Adequate stature (i.e., level of position and perception as a leader) to garner the respect and support of the leadership and faculty of the institution.
3. Leadership credentials in the field or area in which cooperation is to take place.
4. The authority to speak for the institution during negotiations.
5. A personality that is both creative and capable of rising above parochialism.
6. Status that is reasonably comparable to that of the other participants.

It is also important that these representatives choose a group leader who is respected, organized, and objective. The individual should be one who can rise above his personal program and institutional interests and who can encourage other persons to do the same.

Group Dynamics

Typically groups go through three stages in interinstitutional cooperation:

1. Getting to know one another.
2. Trusting each other.
3. Making progress in negotiating the cooperative agreement.

The first stage is often the most difficult and time-consuming. However, the group will not make real progress until the participants become more familiar with each other, and the hidden agendas are out on the table. To encourage the second stage, trust, periods of inactivity and deliberate stalling in the negotiations should be avoided. Since feeling competitive and having vested interests are natural, it is important not to concentrate on motives, but on correcting perceptions and challenging points that are inconsistent with the circumstances. Each participant needs to be seen as a person of good will who must represent the interests of his/her institution but who is still able to compromise.

As the group becomes better acquainted personally and professionally, hidden agendas and conflicts are more likely to emerge and be discussed, and a sense of trust and community established. When participants come to perceive the mutual benefits to be derived from cooperation, real progress can be achieved. Position papers or issue papers can often provide concrete starting points for cooperative agreements.

## Common Goals

An approach which enhances the early stages of cooperation is to establish goals to clarify the target, focus each participant's thinking, and encourage a group perspective to form. These goals should be identified early, and re-emphasized from time to time. Initially, the group should agree on broad philosophical issues and ideals and not try to be too specific.

Institutional autonomy too often has been considered an essential condition for the health of an institution. Insistence on autonomy in forging cooperative agreements is counterproductive, since the overriding common goals for most institutions is serving the needs of the regions in which they are located.

## Institutional Missions

Each institution should have an institutional mission statement which states its raison d'etre and highlights its constituency, the services to be offered, and approaches to be taken. These statements should be presented early in the cooperation process. Since institutions cannot be expected to change their special missions, the group has to understand these position statements and work within the constraints imposed by them. However, none of these mission statements should be in serious conflict with the common goal of serving the needs of the people of the region, so there still should be ample flexibility for cooperative achievement.

## Data Base

A good information base will often aid cooperation. Cooperative efforts should not be stalled while waiting for data, but time and priority must be given to deciding what information is needed and how it is to be obtained.

Successful cooperation depends on objective data. The data need to be sufficiently accurate and complete to be accepted by all participants and respected by those reviewing the findings. The following items should be considered for a data base:

1. The available regional manpower and the needs
2. Existing education and training programs
3. Available support resources
4. Special or unique area resources
5. Existing cooperative structures or mechanisms
6. Organizational and institutional relationships
7. Potential for joint funding
8. Relationships to federal and state programs
9. Minority manpower patterns and needs
10. Regional leadership responsibilities

Human Parameters

The major constraints to effective interinstitutional cooperation are usually neither institutional nor professional, but those due to human shortcomings in relating to one another. Some behavior patterns that can encourage cooperation include the following:

--Appreciating the personal values and needs of individual participants, their goals, and their feelings about the outcome.

--Recognizing that everyone is interested in "What's in it for me?" and that each participant must be able to defend what has been agreed upon at his or her home institution, perhaps to semi-hostile groups.

--Containing competitive instincts, avoiding put-downs, particularly in areas in which some institutions are ahead of others.

--Pointing the way to solutions, acknowledging concerns, delineating the consequences, and setting goals. This involves disturbing the comfortable and comforting the disturbed.

--Recognizing that each individual with his or her unique vantage point is a key element to interinstitutional cooperation.

--Assuring that each person appreciates the perspectives of other persons.

--Recognizing that every group has its own personality and that understanding that personality makes it easier to succeed.

--Coming up with constructive alternatives to issues that are being challenged.

--Being prepared to make reasonable trade-offs and compromises.

Funding

Although helpful, special funding is not critical to successful cooperation; for those genuinely interested in cooperation, initial efforts can begin with little or no funding. (In fact, the possibility of outside funding is one of the strongest motivating forces for getting people to try hard at cooperation.) The desire for cooperation and the philosophical support for it are far more important than financial support.

As cooperation among institutions begins to take shape, the credibility of these efforts rises, and the potential for joint funding of the cooperative activity is significantly increased. There is great interest in encouraging institutions to work together, and so there is a natural tendency of funding

agencies and foundations to try to assist such projects. Each funding opportunity should be weighed carefully, to determine if it is in line with the established goals of the cooperating institutions.

Communication

One of the essential elements in successful interinstitutional cooperation is open communication. If something happens that might be perceived by someone as negative, it is vital that the chairperson or those involved inform the others at the first opportunity. Lack of communication becomes a major block to cooperation.

There must also be regular and timely communication between the representative and the home campus. Each participant must take on this responsibility. The dialogue on the status of cooperative efforts should be factual and complete.

Perceptions

As interinstitutional cooperation progresses, it is important to be aware of how the effort is being perceived by others. Reactions will range from supportive to critical. How the effort will be perceived may depend on what the representatives of the institutions do and say. For instance, if a staff member from a participating institution publicly criticizes the effort, it will be harder to convince outsiders of the potential for its success. If an institution's representative attacks another institution's representative, then he or she weakens the credibility of the effort. And if it appears to the supporters of an institution that their side came off second best in a compromise, then that institution will find it more difficult to accept and approve

the proposal. Such perceptions are critical to the success of cooperative activities.

Documentation

During the course of discussion, many agreements will be reached and accepted. For simple matters oral agreements may suffice, but they will not be adequate for substantive issues. Before they are formally accepted, agreements of substance must be written down in such a way that they are not ambiguous to the representatives or outsiders. Since fuzziness in agreements leads to misunderstandings which grow into major barriers, written agreements reflect the accepted concepts, and provide formal evidence to the home institution and the outside world that progress is being made.

Institutional and Faculty Psychology

The faculties of institutions of higher education tend to be traditional and elitist. As a result, institutions and faculties often resist change, overtly and covertly, because they do not want to be controlled, even partially, by others. They tend to be overly protective of their institutional prerogatives and their personal and professional interests. Thus, they are tempted to return to the traditional pattern at any available opportunity, making cooperation difficult. Because of these psychological barriers to cooperation, chief executives and other institutional leaders need to continually reaffirm their belief in cooperation for programs to survive.

Outside Agencies

Cooperative activities need guidance from practitioners and the input of related community and professional organizations. With their advice and

assistance, the probability that the cooperative agreements will be accepted is greatly enhanced. For example, the state's coordinating board or council for higher education should be consulted regularly.

On the other hand, cooperative efforts should not be held up for the sanction of some outside agency. Further, such agencies should not be allowed to lead the thrust of cooperation off course and retard its progress.

Institutionalization

Institutionalization of cooperation is the process by which cooperation becomes part of the ongoing program of the institutions. It requires that faculties and administrators at the cooperating institutions know the concepts of cooperation and accept its conditions. Because acceptance depends on communication with all faculty members, each of whom has his or her self-interests, institutionalization of cooperation is not an easy task. Several steps can enhance the effort, including:

1. Strengthening the mechanisms for communicating the concept of cooperation in the institution.
2. Continuing support of cooperative efforts by administrators at all levels.
3. Holding special seminars and programs on cooperation and its potential for advancing the institution.
4. Establishing multi-institutional conferences for faculty and administrators to disseminate information about the cooperative arrangement, and enlisting their assistance in broadening the base in their area of influence.

## Summary and Recommendations

Interinstitutional cooperation is the process whereby institutions share their resources, expertise, and leadership so that their constituencies may be served more effectively. Creative approaches to interinstitutional cooperation can potentially improve services to students, faculties, and communities, and timeliness of initiative is often critical to cooperative efforts.

With budget limitations, accountability requirements, falling enrollments, and society's need for new kinds of services, interinstitutional cooperation promises to be a significant avenue for higher education to meet its future obligations. The time is right, and the cooperation mechanisms are available.

# CHAPTER 6 -- SHARING: A RECAPITULATION AND SOME CONSIDERATIONS FOR ACTION

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Three successful methods of sharing resources in allied health education have been reviewed in the previous chapters: a substate regional consortium described by Lick and Moses; a statewide linkage of educational institutions described by Blayney; and an interstate agreement described by Freeland and Abadie.

The organizational form, administrative arrangements, and resources shared are different in each case. However, the three programs are alike in basic aspects: institutions had resources that could be shared; individuals took initiative in developing the sharing concept; the organizational period took considerable time and patience; and the sharing program benefited all the participants.

## Exploring Sharing Opportunities

Effective sharing arrangements can occur at a variety of levels. For example, there are possible sharing arrangements within a single school or institution. Often allied health programs become isolated from one another and each program becomes protective of its assets and resources. Administrative leadership, from the school or program level, can encourage cooperation and

sharing among programs. This kind of local sharing is relatively simple to arrange and has a high likelihood of payoff.

An early consideration is identifying the materials or services to be shared. Often cooperative arrangements begin when a program lacks something that a neighboring institution has and is not using to full capacity. In such cases, one sharing asset is evident, but it is necessary to identify other items or services that may be exchanged. Once the collaborative arrangement is in operation, each program will likely find that its quality and scope have been improved as a result of the exchange.

Tangible items that have identifiable economic value are easiest to use in a sharing program, and the savings to the participating institutions are measurable. Less tangible items, such as data, information and ideas, can be shared although there may be difficulties in determining their value in an exchange. A climate of cooperation will encourage the free distribution of ideas and information, with the sharing agreements concerned with other types of resources.

With the shortage of qualified allied health faculty, sharing of faculty expertise can strengthen programs. While there has been considerable interest among administrators in faculty exchanges, moving people for a quarter, semester, or a year can be too expensive and too disruptive for both faculty members and institutions. Successful faculty exchanges may be more easily accomplished in a shorter time period -- perhaps several days or a week. An allied health specialist could concentrate his or her expertise on a few concepts or techniques for a limited time, and this approach would require only minor curriculum modification. Logistical and financial difficulties for faculty

exchange could be eased if the receiving institution or its staff provided housing for visiting faculty.

## Taking the Initiative

For good sharing opportunities to exist, someone must propose the idea. Initial reactions to the suggestion may range from enthusiastic to negative, but unless the responses are strongly adverse or indifferent, the matter should be pursued.

Discussion of a sharing arrangement is best initiated by the individual who is first to identify a need that could be resolved by cooperation. In developing a program that will involve several independent departments or institutions, there are advantages in presenting the idea in general terms and deferring detailed planning until the concept has been accepted. All participants need an opportunity to contribute their ideas if they are to develop a sense of ownership in the program.

A prime consideration in proposing resource sharing is assuring that the arrangement will be advantageous to all participants. A sharing arrangement may require that participants voluntarily give up some individual decision to a group decision-making process. The advantages of cooperation must be of sufficient importance to all parties to more than compensate for sharing decisions, if the program is to be lasting.

## Developing an Organization

A difficult phase of creating a sharing arrangement may be the development of a process to implement the plan. The case studies in this publication describe organizational steps which representatives took to come to agreement.

The types of institutional representatives selected affect the planning process. Plans for cooperative activities should involve the faculty members and program directors who will be using and contributing the shared resources. Administrative representation is also needed, particularly for entering into agreements. Administrative involvement at the planning stage can facilitate the process, but the details of the sharing arrangements should be worked out by the program people who will have to carry them out.

The organizational process can range from highly structured to informal. Excessively formal approaches can hinder the developmental process and curtail exploratory discussion. Unless there is consensus from the outset, preparation of a detailed written agreement should be postponed until the issues have been resolved and the anxieties relieved. Some record of activities should be kept in order to avoid rehashing issues, but this can be done through minutes or by periodic progress reports.

Open communications during the organizational period among the administrators, faculty, and other key participants encourage interest in and commitment to the sharing program. A cooperative venture can stimulate good public relations for the institutions within their communities when the positive aspects of the program are emphasized.

In summary, sharing arrangements can provide advantages to allied health programs, such as extending resources, containing costs, avoiding duplication, and improving program quality. Establishing the organizational structure for sharing requires work, but individuals who have been involved in such efforts, such as the writers of the case studies, indicate the results were worth the effort.